Chapter 9
Intercultural Rhetorical Dimensions of Health Literacy and Medicine

ABSTRACT

This chapter examines the relations between health/medicine and rhetoric across cultures, demonstrating the need to have culturally and linguistically appropriate health care communications. It compares the rhetorical strategies of two heart health manuals and informed consent, showing how culture is embedded in these documents and how to adapt them to target cultures.

INTRODUCTION

Now, it is widely recognized that medicine, health care and health communications are not universal but are intimately connected to local cultures and medical traditions (Purnell, 2009). Consequently, health and medical services are best delivered using the cultural and communication patterns of the patients (see, for example, Purnell, 2009; Tseng & Streltzer, 2008). The intercultural dimensions of health and medical treatment have undergone extensive research and practice, not only in the United States, but all around the world. Not surprisingly, much research has focused on improving health disparities or differences in health behaviors, based on cultural and ethnic groups, using culturally competent health care. This is especially true with Latinos or Hispanics (hablamosjuntos.org), which make up the largest U.S. minority. For example, new critical research has focused on the roles of Spanish translators and new multimedia forms to bridge cultural and linguistic differences for Hispanic populations (Angelelli & Jacobson, 2009).

This move towards "culturally competent health care" is so critical to reducing health disparities in the United States that it is mandated at the federal and many state levels (hrsa.gov/culturalcompetence). For example, the U.S. government has developed (and mandated) 14 dimensions of "culturally competent health care" for the four major U.S. minority groups (www.hrsa.gov/culturalcompetence). These 14 dimensions are titled *National Standards on Culturally and Linguistically Appropriate Services* and are listed in Table 1.

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Table 1. The Nation Standards on Culturally and Linguistically Appropriate Services

Standard 1	Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
Standard 2	Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
Standard 3	Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
Standard 4	Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
Standard 5	Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
Standard 6	Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
Standard 7	Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
Standard 8	Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
Standard 9	Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
Standard 10	Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
Standard 11	Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
Standard 12	Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
Standard 13	Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
Standard 14	Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). These 14 standards present a comprehensive approach to the cultural competence, but in practice, much of cultural competence is reduced to translation and understanding the medical traditions of the patients' cultures, two critical components indeed, but far from true intercultural competence. Thus, the purpose of this chapter is not to review the body of literature and research on culturally competent health care; rather, this chapter demonstrates how to develop culturally competent health communications with each of the 14 standards. In addition, this chapter severely critiques many of the assumptions of these standards, including their definitions of